Personal Accident for Voluntary Workers
Claim Form

This form should be completed and returned to us via email (claims@acsfinancial.com.au) , facsimile (1300 881 552) or post.

Section A. Policy Information

Policy Number: Expiry Date: DD / MM / YYYY

Insured Name:

Insured Postal Address: Suburb: State: Postcode

Insured Contact Name: Email:

Phone (BH): ( ) Mobile: Fax: ( )

Section B. Claimant Details

Insured Contact Name: Date of Birth: DD / MM / YYYY Male Female

Parent/Legal Guardian Name (if claimant under 18 years of age):

Residential Address Suburb: State: Postcode

Email: Mobile:

Occupation:

Complete bank details for payments

Bank: Branch:

BSB Account No.: Account Name:

Section C. ACCIDENT

1. Injury date and nature

Date of injury: DD / MM / YYYY Time: am pm

Nature of injury:

Cause of injury:

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Section C. ACCIDENT (Continued)

Details of activity when accident occurred:

Address where injury occured: | Suburb: | State: | Postcode

Was this an authorised voluntary activity? ◯ Yes ◯ No

2. Witness Details

Were there any witnesses to the accident? ◯ Yes ◯ No Witness Name:

Witness Email: | Witness Phone:

3. Previous Claims

Give details of any previous claim made for any previous injury against any insurance company:
(please use separate sheet if insufficient space)

Section D. Medical History & Treatment

1. Have you ever had this or a similar condition in the past? ◯ No ◯ Yes Date: DD / MM / YYYY

2. Was hospital treatment required? ◯ Yes ◯ No

If yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From: DD / MM / YYYY **To:** DD / MM / YYYY **Hospital Name:**

Hospital Address: | **Suburb:** | **State:** | **Postcode**

3. When did you first obtain treatment from a doctor? Date: DD / MM / YYYY Time: ◯ am ◯ pm

Doctor's Name:	**Address:**	**Telephone Number:**

Is this doctor still treating you for the injury/illness? ◯ Yes ◯ No

Is this doctor your regular doctor? (If no, please give details below) ◯ Yes ◯ No

Doctor's Name:	**Address:**	**Telephone Number:**

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Section D. Medical History & Treatment (Continued)

4. Are there, or do you envisage, any complications? ◯ Yes ◯ No

Details:

5. Is there any condition (past or present) which may have contributed directly, or indirectly, to the injury or which may be likely to retard your recovery? (If yes, please give details below) ◯ No ◯ Yes

6. Are you now:

Fully Recovered	◯ Yes ◯ No	When did you return to school or work?	DD / MM / YYYY	
Partially Recovered	◯ Yes ◯ No	When did you return to school or work undertaking partial duties?	DD / MM / YYYY	
Totally Disabled	◯ Yes ◯ No	When do you expect to return to school or work?	DD / MM / YYYY	

7. Have you made, or will you make, a claim for benefits under any Workers Compensation Act or Transportation Act because of the injury? (If yes, please give details below) ◯ No ◯ Yes

	Claim Number (if known):	Name:
Employer:		

Address: **Suburb:** **State:** **Postcode:**

	Claim Number (if known):	Name:
Workers Comp/ Transport Insurer:		

Address: **Suburb:** **State:** **Postcode:**

8. Do you have private health cover? (If yes, please give details below) ◯ Yes ◯ No

Please note that if you have private health insurance you must first make a claim on them.

Insurer: **Type of Cover:**

Section E. Claimed Expenses

1. Are you claiming medical expenses? ◯ Yes ◯ No If yes, please complete **Medical Expenses Form**

2. Are you claiming for loss of income? ◯ Yes ◯ No If yes, please complete 3 and 4 below:

We are unable to process benefit payments without a confirmation of income.

3. Are you self employed? ◯ Yes ◯ No

If yes, confirmation of earnings MUST be submitted with claim form (i.e. Tax Return & Profit/Loss Statement).

Section E. Claimed Expenses (Continued)

4. **Employer Declaration**

If employed as a wage earner, the below is to be completed by your employer (or attach payslip)

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an injury suffered whilst _____ on the DD / MM / YYYY

He/she has been incapacitated since DD / MM / YYYY and is expected to/did resume duties on DD / MM / YYYY

His/her gross salary, exclusive of bonuses, commission, allowances, etc., at the date of injury was **$** _____ per week.

During the period of incapacity he/she received **$** _____ from DD / MM / YYYY to DD / MM / YYYY

Name of Company _____ Has been employed since: DD / MM / YYYY

Address: _____ Suburb: _____ State: _____ Postcode _____

Name of Supervisor or Paymaster _____ Telephone Number _____

Signature of Supervisor or Paymaster _____ **Date** DD / MM / YYYY

5. Other. Please specify:

Section F. Church/Club/Association Declaration - COMPULSORY

I hereby certify that whilst participating in authorised voluntary activity _____ was injured on the DD / MM / YYYY

Name of Insured Entity: _____

Name of Authorised Officer for Insured Entity: _____ Phone (BH): ( ) _____

Signature of Authorised Officer for Insured Entity _____ **Date** DD / MM / YYYY

Section G. Complaints Process

ACS Financial is a broker for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute, and after talking to ACS Financial staff you are still dissatisfied and you wish to take the matter further , we have a Complaints and Dispute Resolution Procedure which you will find at www.acsfinancial.com.au/customer-support - important information.

If you are dissatisfied with our decision or the way we handled your complaint, you may be able to refer your complaint to the Australian Financial Complaints Authority (AFCA). Access to the Complaints Process is free of charge to you.

Section H. Privacy Statement

ACS Financial Pty Ltd (ACN 062 448 122) (AFSL 247388) (ABN 91 460 778 961) ("ACS Financial") ("we"/"us") is committed to ensuring the confidentiality and security of your personal information.

We are bound by the Australian Privacy Principles ("APPs") under the Privacy Act 1988 (Cth) regarding the way we handle your personal information.

We have implemented a Privacy Policy, under the APPs, which explains how we collect, hold, use and disclose your personal information, and how you can access and/or correct that information. Nothing in this policy limits any of our obligations at law.

You can obtain a copy of the 'ACS Group Privacy Policy' by calling 1800 646 777 or by downloading a copy at www.acsfinancial.com.au/Customer-Support - Privacy Policy.

Your personal information is collected for the purposes set out in the ACS Group Privacy Policy and is relevant to any recommendation that you acquire or offer to arrange for the issue of an insurance policy or a mutual protection to you as well as the amount of your premiums or contributions or the assessment of any claims made by you or your personal representative. If you do not provide the full information that we request and disclose every matter that you know or could reasonably be expected to know, we may be unable to assist you with your application or if you accept insurance cover and/or mutual protections you may be in breach of your Duty of Disclosure.

Ensure that you seek permission from individuals before you provide us with their personal information, and let them know about this Privacy Statement and how they can contact us if they want to access or correct information we hold about them.

We do not trade, rent or sell your personal information. We may use your personal information to provide you with information about other products, services and special offers. If you do not want your personal information used in this way, please write or email ACS Insurance Services at insuranceservices@acsfinancial.com.au with your opt-out request and we will arrange accordingly.

Section I. Declaration

Declaration

I/We declare that:

- the information I/we have provided is true, complete and correct to the best of my/our knowledge, and I/we will inform ACS Financial should any of this information change in the future;
- the information I/we have provided includes every matter known to me/us that is relevant to the claim;
- I/We are duly authorised to act for and on behalf of the above-named organisation and have completed this claim form on behalf of it and all those who may be entitled to Protection, after due enquiry of all directors or office bearers and senior staff;
- I/We authorise ACS Financial to obtain from or give to ACS Mutual or insurance reference bureau or credit reporting agency any personal information relating to this or other insurance cover/Protection relating to me or the above-named organisation including claims or credit history; and
- I/We understand that I/we can obtain the ACS Group Privacy Policy, access personal information held about me/us, or raise privacy concerns by calling the ACS Group Privacy Officer on 1800 646 777, and consent to ACS Mutual and ACS Financial and their service providers using and disclosing my/our information in the way described in the Privacy Statement. Where information about a third party individual is supplied, I/we declare that the person has been made aware of that fact and of the Privacy Policy.

Section J. Authority

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACS Financial or its representatives, any and all information with respect to any injury, medical history, consultation, prescriptions, or treatment, copies of all hospital and medical records as requested.

Signature of Claimant/ Parent/Legal Guardian

Date DD / MM / YYYY

Full Name:

Personal Accident for Voluntary Workers
Medical Certificate

THE CLAIMANT MUST OBTAIN AT THEIR OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES
IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRIES

Section K.

1. Patient Details

Full Name:

Date of Birth: DD / MM / YYYY

Please give complete diagnosis of this condition:

2. History

When did the patient first receive medical treatment? DD / MM / YYYY

Is there a previous history of this or a similar condition? Yes No If yes, please provide detials:

How long have you known the patient? Day/s Month/s Year/s

Are you the regular general practitioner? Yes No If no, please advise who is:

Regular Doctor's Name: **Address:** **Telephone Number:**

3. Injury

When did the patient first suffer the injury? DD / MM / YYYY

What was the cause of the injury?

4. Degree of Disability

When was the patient obliged to cease school or work? DD / MM / YYYY

When was/will the patient be able to return to school or work?

Some duties? DD / MM / YYYY Full dutues? DD / MM / YYYY

5. Treatment of Present Condition

When were you consulted? Initially DD / MM / YYYY Most recently DD / MM / YYYY

Was the patient confined to hospital?

No Yes From: DD / MM / YYYY To: DD / MM / YYYY If 'yes', please advise:

Name and Address of Hospital:

What other surgical or medical procedures are possibly contemplated?

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5. Treatment of Present Condition (Continued)

Are there any underlying conditions affecting recovery from the current conditions? ◯ Yes ◯ No

If 'yes' please advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Full Name of Medical Practitioner:

Qualifications:

Postal Address:

Suburb:

State:

Postcode

Phone (BH): ( )

Fax: ( )

Signature of Medical Practitioner

Date DD / MM / YYYY

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